

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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STATE ARKANSASMETHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

Revised: April 1, 1979

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4. a. Skilled Nursing Home Payment
Reimbursement on Reasonable Cost-Related Basis - See Appendix I.
14. a. Services for individuals age 65 or older in institutions for tuberculosis
(2) Skilled nursing facility services -
Reimbursement on Reasonable Cost-Related Basis - See Appendix I.
(3) Intermediate care facility services -
Reimbursement on Reasonable Cost-Related Basis - See Appendix I.
14. b. Services for individuals age 65 or older in institutions for mental diseases.
(2) Skilled nursing facility services
Reimbursement on Reasonable Cost-Related Basis - See Appendix I.
(3) Intermediate care facility services
(a) Private Nursing Care Facilities - Reimbursement on Reasonable Cost-Related Basis - See Appendix I.
(b) State Operated Facilities - Reimbursement on Reasonable Cost-Related Basis - See Appendix I.
15. Intermediate care facilities services (Other than such services in an institution for tuberculosis or mental diseases) for persons determined, in accordance with 1902 (a)(31)(A) of the Act, to be in need of such care.
Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

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DEPARTMENT OF HUMAN SERVICES

Medical Assistance Program Manual Of Cost Reimbursement Rules For Long Term Care Facilities

(July 1, 1999)



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SUPERSEDES: TN - 76-34

Introduction

This manual is for use by providers, their accountants and the Department of Human Services in determining the allowable and reasonable cost of Long Term Care services furnished to Medicaid recipients. The manual contains procedures to be used by each provider in accounting for its operations and in reporting the cost of care and services to the Department of Human Services.

The Long Term Care Program is administered by the Office of Long Term Care, within the Division of Medical Services. The program herein adopted is in accordance with Federal Statute in the Social Security Act § 1902 (a) (13) (A) and Public Law 105-33. The applicable Federal Regulations begin at 42 Code of Federal Regulations § 430. Each Long Term Care Facility which has contractually agreed to participate in the Title XIX Program will adopt the procedures set forth in this manual and must file the required cost reports.

As interpretations and changes of this program are made, appropriate revisions of the manual will be furnished to each provider and interested party. Care should be taken to insure that revisions to the manual are promptly inserted.

Questions relating to this program or relating to the interpretation of any of the provisions included in this manual should be addressed to:

Department of Human Services
Division of Medical Services
P. O. Box 1437, Slot 1104
Little Rock, AR 72203-1437
(501) 682-1875

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Chapter 1 - Principles and Procedures

1-1 General Principles

All Long Term Care Facilities will be reimbursed according to the principles and procedures specified in these regulations. Allowable costs are those costs necessary and reasonable for performance of covered services required by Medicaid recipients.

A facility's direct and indirect allowable costs related to covered services will be considered in the findings and allocation of costs to the Medical Assistance Program for its eligible recipients. Total allowable, reasonable costs after removal of direct Medicare ancillary cost of a facility shall be apportioned on a per resident day basis between third-party payers and other residents so that the share borne by Medicaid under Title XIX is based upon actual services and costs related to Medical Assistance recipients.

Costs included in the per diem rate will be those necessary to be incurred by efficiently and economically operated facilities to comply with all requirements of participation in the Medicaid program.

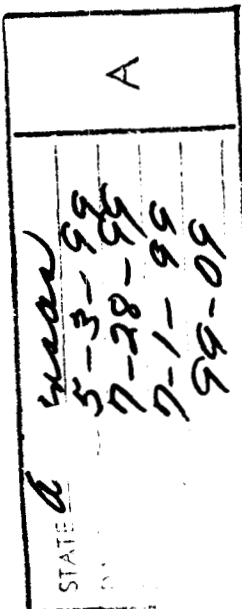
1-2 Record Keeping

Providers are required to maintain adequate financial records and statistical data for proper determination of costs payable under the program. The cost report is to be based on financial and statistical records maintained by the facility. Cost information must be current, accurate and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, and original evidence of cost (purchase requisitions for supplies, invoices, paid checks, inventories, time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable costs. A provider must make available (within the state) all financial and statistical records to the Department or its representatives for the purpose of determining compliance with the provisions of this program. Providers who find it difficult to provide home office records at the audit or review site can at their option, reimburse the Department for all costs associated with the travel of Department employees or their representatives in accordance with state laws and rules for the reimbursement of travel for state employees.

The Financial and Statistical Report/Cost Report and Schedules sets forth information to be reported. The report must be prepared on the accrual basis of accounting in accordance with instructions for completion of the Cost Report. Government facilities have the option to use the cash basis of accounting for reporting.

All financial and statistical records, including cost reports, must be retained for a period of five years after submission to the Department.

SUPERSEDES: TN - 97-11 :



1-3 Activities Not Related to Resident Care

If the provider conducts activities not related to resident care, additional accounts must be added to accommodate those activities.

1-4 Accrual and Cash Basis of Accounting

For non-governmental providers, the Financial and Statistical Report must be filed using information stated on the accrual method of accounting. The Chart of Accounts is designed to be used in a complete accrual accounting system.

Financial information stated on an accrual basis is essential to insure that the proper reimbursement is made to providers. The measurement of the cost of services performed must include all supplies, salaries, services and other expenses incurred, regardless of whether or not those items have been paid.

Many providers will find that the accounting for all transactions on a pure accrual basis may create undue workloads. Also, many providers account for their activities on a strict cash basis and they are satisfied with the management information produced from their existing system. Therefore, in lieu of accounting for all transactions on an accrual basis, the provider may maintain his records on a cash basis during the year and convert to an accrual basis at the beginning and end of the year for reporting purposes.

1-5 Chart of Accounts

The applicable Chart of Accounts shall be used by all Long Term Care Facilities participating in the Title XIX Program. Each Chart of Accounts provides for the basic classifications of all assets, liabilities, income and expense necessary for the preparation of the Cost Report. Providers may take some latitude in assigning account numbers but must maintain the basic Chart of Accounts.

1-6

Cost Reporting Requirements

All providers in operation under a valid Medicaid agreement for long term care services must file a Financial and Statistical Report (commonly referred to as a Cost Report or FSR). Cost reports for periods less than the full reporting period are required of the owner or operator of record on the last day of the reporting period unless specified otherwise in these regulations. If the facility was not certified for Medicaid participation at date of first opening or acquisition, then the reporting period shall begin at official certification date rather than the date of acquisition.

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A. When To File

Nursing facilities will report cost on a fiscal year ending June 30. Cost reports will be due within 90 days after the end of the reporting period. Under 16 Bed ICF/MR providers will report cost on a calendar year basis. The cost report will be due within 90 days of the end of the reporting period. Benton Nursing Facility located at the Benton Services Center and the 16 Bed and over ICF/MR providers will report cost semi-annually (January 1 - June 30) and (July 1 - December 31) with the cost reports being due the second Tuesday of February and August. Should the due date fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day. Reports are to be delivered to the Office of Long Term Care or postmarked on or before the applicable due date.

Providers who fail to submit cost reports and other required schedules and information by the due date or extended due date have committed a Class D Violation of Arkansas Code 20-10-205. Civil penalties associated with failure to timely submit a cost report for Long Term Care Facilities are detailed in Section 1-11 of this Manual.

B. Extensions for Filing

If a written request for an extension is received by the Office of Long Term Care ten or more working days in advance of the report due date and a written extension is granted, a penalty will not be applied, provided the extended due date is met. Each request for extension will be considered on its merit. No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which causes a late report. In no instance will an extension be granted for more than 30 days.

C. What to Submit

In addition to the applicable cost report forms, providers must submit the following:

1. Most recently completed Medicare Cost Report,
2. Working trial balance and related working papers identifying the cost report line each account is included on,
3. Detailed depreciation schedule,
4. Any work papers used to compute adjustments made on the cost report,

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